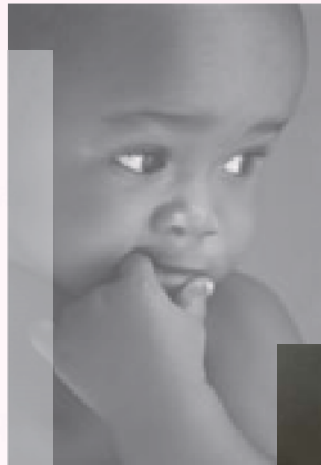


A Report on New Jersey's Federally Qualified Health Centers (FQHCs) Performance in Prenatal Care

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Introduction:

New Jersey's Federally Qualified Health Centers (FQHCs) deliver many essential primary and preventive care services to the medically underserved populations throughout the state. Prenatal care and well baby care services constitute a major segment of services provided by many of New Jersey's FQHCs. Among New Jersey's nineteen FQHCs, fourteen currently provide pre-natal care services through obstetricians/gynecologists, certified nurse midwives, and nurse practitioners who have admitting privileges at affiliated local hospitals. Majority of patients who receive their prenatal care at the centers also deliver under the care of their providers. In 2005, among 6,581 patients who delivered, 5,969 deliveries were performed by health center providers (91%). In 2004, among the 6,544 patients who delivered, 6,285 deliveries were performed by health center providers (96%).¹ These numbers may be understated because New Jersey primary care centers that did not submit their UDS for 2004 and 2005 were not included in the total number of pre-natal care patients and total number of deliveries being accounted in this report.

Poverty and consequent lack of health insurance is a major reason why many women forego timely and adequate prenatal care, which can impact the well being of both the mother and the newborn. In an issue brief compiled by the Pregnancy Risk Assessment Monitoring System (PRAMS) it was reported that about 65% of women who had a live birth between 2002 and 2005 were covered by private insurance for their prenatal care services. During that same period, 28% of the pregnancies were provided care through New Jersey FamilyCare. In New Jersey, pregnant women who do not have

¹ Source: 2004 and 2005 Uniform Data System (UDS) data, a Bureau of Primary Health Care (BPHC)/Health Resources Services Administration (HRSA) mandated data reporting system for all 330 grant funded health centers.

privately funded health insurance are able to obtain care via the New Jersey FamilyCare program which provides health insurance to near-poverty families.²

While publicly funded health insurance covered many of the uninsured, about 5% of those pregnancies, total of 5,000 births annually, had no insurance coverage for prenatal care during that same period.³ In this regard, New Jersey's FQHCs play a major role in extending prenatal care to pregnant women enrolled in both FamilyCare and also to uninsured women by providing services on a sliding fee scale that are subsidized by charity care funds from the state. According to 2005 data on insurance profile of health center patients, about 7.4% had private insurance, 41.1% had Medicaid/SCHIP coverage, 3.9% Medicare, and an overwhelming 47.6% uninsured.⁴ Given this distribution, it is very likely that majority of health center prenatal care users are either publicly insured or uninsured.

Importance of Prenatal Care:

Prenatal care is important because poor birth outcomes such as infant mortality, pre-term births, and low-birth weights among newborns are preventable to a large extent with proper and early prenatal care.⁵ All three birth outcomes are inextricably related. Birth weight is closely tied to gestational length among other factors. Generally, full term infants (at least 36 weeks of gestation) tend to have normal birth weights (2500 grams or more) than infants born before 35 weeks of gestation. Low birth weight is one of the

² New Jersey Pregnancy Risk Assessment Monitoring System (PRAMS), Division of Family Health Services, New Jersey Department of Health and Senior Services (NJDHSS): *A survey for Healthier babies in New Jersey*. <http://nj.gov/health/fhs/professional/prams.shtml>

³ *ibid.*

⁴ National Association of Community Health Centers, Inc (NACHC). *Health Center Fact Sheet*. 2005.

⁵ Shi, Leiyu., J. Macinko, B. Starfield, J Xu, J Regan, R. Politzer and J Wulu. "Primary Care, Infant Mortality, and Low Birth Weight in the States of the USA." *Journal of Epidemiology and Community Health*. 2004. 58: 374-380.

primary causes of infant mortality, and pre-term births often contribute to low birth weights. Aside from infant mortality, even when low birth weight infants survive, they are at a much higher risk for long-term medical conditions, such as, cerebral palsy, mental retardation, vision and hearing impairments, etc. Additionally, there are excessive financial costs associated with treatment of low birth weight infants.⁶ The Centers for Disease Control and Prevention (CDC) estimates that the average extra cost of treating each low birthweight baby during the first year of life is \$15,000.⁷

Early enrollment into prenatal care is considered to be an important determinant of healthy birth outcomes. Prenatal care patients receive routine health exams that monitor fetal growth and development, receive advice on proper nutrition, and get medical attention for any health issues that may arise throughout the course of their pregnancy. Access to prenatal care also provides the best opportunity to identify and address behavioral practices such as tobacco, alcohol, and drug use that can contribute to poor birth outcomes.⁸ In a report released by the Center for Health Statistics, New Jersey Department of Health and Senior Services (NJDHSS), 2003 infant mortality rates were found to be six times higher for women who received no prenatal care than women who received prenatal care. Given the significance of prenatal care on the health of women and their infants, what kind of impact are the FQHCs having on the overall health status of their prenatal care service users?

⁶ NJDHSS. *Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium*. Volume 1, p. 56.

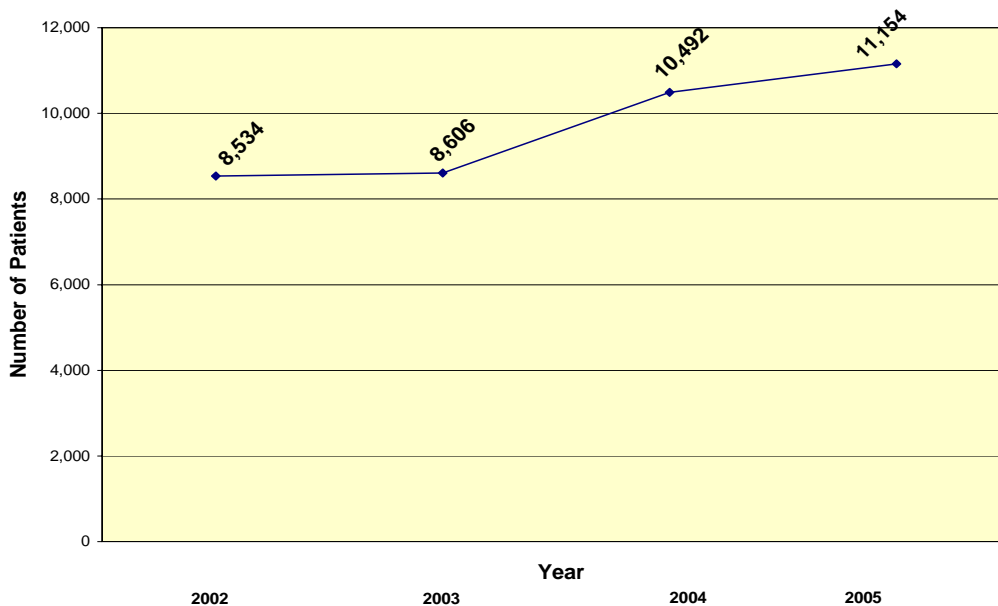
⁷ United States Department of Health and Human Services, Centers for Disease Control and Prevention. *An Ounce of Prevention, What Are The Returns*. 1999, p. 13.

⁸ NJDHSS. *Healthy New Jersey 2010: A Health Agenda for the First Decade of the New Millennium*. Volume 1, p. 47.

FQHCs and Prenatal Care

Among New Jersey's nineteen health centers, in 2005, thirteen health centers provided prenatal care services to 11,154 (12 centers reporting) expecting mothers statewide. However, this total is understated because data from one health center was not available for 2005. Additionally, the number of users in this category is likely to be higher for 2006 as one more health center has expanded its services to include prenatal care. Also, the total number of prenatal care patients served by the health centers over the past few years has been increasing gradually (see Figure 1).

Figure 1: Number of Health Center Prenatal Care Patients



It is important to note that by virtue of caring for a population that is predominantly low-income, uninsured and underinsured; the health centers extend prenatal care to a population that will otherwise go without such care. And as statewide and

health center specific birth data indicates, not only do these centers extend prenatal care to the disadvantaged and the disenfranchised, their quality of care is such that they produce comparable if not better birth outcomes for a predominantly high risk population.⁹

Evaluating Health Center Performance in Prenatal Care

Since prenatal care is assumed to have an important impact on birth outcomes, in the absence of a more direct measure for evaluating health center performance in provision of prenatal care, this report looks at birth outcomes of pre-natal care patients at the health centers. Health center performance in this area is best evaluated against the backdrop of birth outcomes state wide and also against the state goals in this area.

The ideal situation would be to compare all three birth outcomes, pre-term births, birth weights, and infant mortality rates of health center prenatal care patients in the overall context of statewide birth data. While both birth weight and term of birth data is available for statewide births, due to lack of reporting, the only birth outcome data available from the health centers is birthweight of babies born under health center provider care. The year for which complete data is available for both statewide births and births to health center prenatal care patients is 2005.

However, in the absence of other birth outcome data, birthweight of babies can provide an important criterion for evaluating health center performance in the provision of prenatal care. In fact, according to the Healthy New Jersey 2010 Volume 1, “infant

⁹ Health center patients are considered more at risk for poor birth outcomes due to lack of access to regular care, nutrition, harmful habits, lack of health education, etc.

birthweight is one of the strongest predictors of infant survival and subsequent quality of life”. As reported by DHSS, in 2005, there were a total of 108, 186 live births in New Jersey. Among these, about 6,611¹⁰ births were to health center pre-natal care patients. Compared to babies born under the care of other providers, babies born under the care of FQHC providers had a lower incidence of very low and low birth weights and a higher incidence of normal birth weights (please see table 1). For comparative purposes, statewide births¹¹, excluding health center births for 2005 were 101,575. It should be

Table 1: FQHC and Other Birth Weight Information

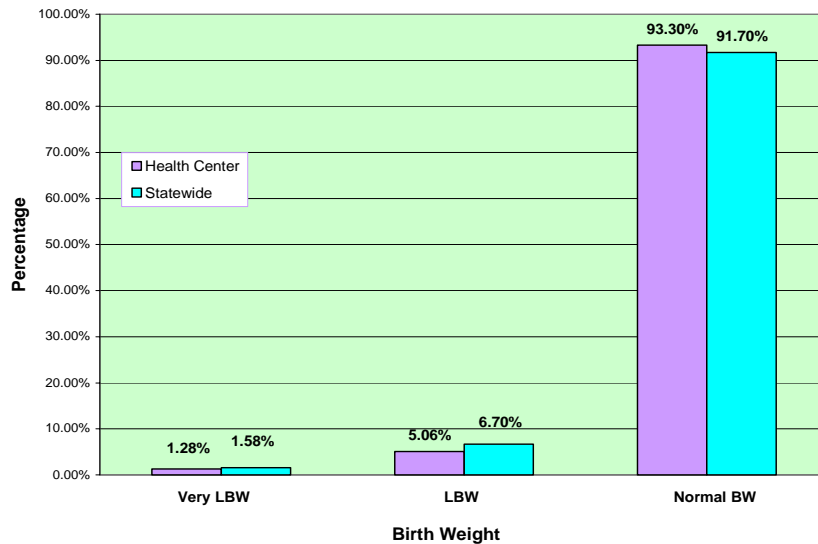
	Births (Other Provider Care)	Births (FQHC Provider Care)
Very Low Birthweight	1.58%	1.28%
Low Birthweight	6.7%	5.06%
Normal Birthweight	91.7%	93.3%

noted here that birthweight information for statewide births was unavailable for 23 new births. As a result, when the statewide number of newborns in different birthweight categories is added up, they do not equal 101,575 because of the missing data. So, statewide births (%) presented in Figure 2 was based on a total of 101,552 statewide births in three different birth weight categories.

¹⁰ Total number of deliveries (6,581) reported for 2005 on page 1 do not match the total number of births reported on page 7 due to multiple births to pre-natal care patients.

¹¹ Statewide birth data was provided by the Maternal and Child Health Epidemiology Program, Division of Family Health Services, NJDHSS. This data is available at the Center for Health Statistics, NJDHSS. <http://nj.gov/health/chs>.

Figure 2: % of Babies Born in Different Birthweight Categories



Among 2005 newborns throughout the state, about 1,604 (1.58%) were in the very low birthweight category (weighing less than 1500 grams); 6,807 (6.7%) were in the low birthweight category (between 1501-2500 grams); and 93,141 (91.7%) were in the normal birthweight category (more than 2500 grams). Among babies born under health center care, 85 (1.28%) were in very low birthweight category; 336 (5.06%) were in the low birthweight category; and 6190 (93.3%) were in the normal birthweight category. This comparison clearly indicates that babies born under health center provider care had lower incidence of both very low and low birth weights, and a higher incidence of normal birthweight babies.

When compared with state goals of reducing low birthweight and very low birthweight babies, health centers perform better than other health care organizations. The Healthy New Jersey 2010 program aims to reduce the percentage of low birth weight infants to 6.0% and very low birth weight infants to 1.0% of all infants. The percentage

of babies in the low birth weight category born under health center care is 5.06%, which is already lower than the stated goal (6.0%); and the percentage of very low birth weight babies is very close to the stated goal (1.28%). In this category also, the health centers perform better than other medical providers statewide.

The fact that health centers perform notably well in providing better health outcomes for their pre-natal care patients has also been reported in studies focused on community health center performance nationwide. In a study investigating whether community health centers reduce racial/ethnic disparities in perinatal care and birth outcomes, Shi et al. reported that despite serving a low-income, high-risk population, health centers produce better birth outcomes for their prenatal care patients compared to the general population.¹²

As indicated earlier in this report, a major difficulty in evaluating health center performance on all three birth outcome measures lies in the lack of availability and reporting of such information by the health centers. The only outcome reported by all the health centers providing prenatal care is birth weight information of newborns. This data requirement is mandated for all 330 grant funded health centers by the Bureau of Primary Health Care (BPHC) in the Health Resources and Services Administration (HRSA) as part of their annual data reporting system. This requirement helps the health centers obtain this information from the hospitals where most births take place. With regard to other birth outcome data, which are not part of the mandated reporting system; most health centers are unable to report these data because the affiliated hospitals do not

¹² Shi, Leiyu, Gregory D. Stevens, John T. Wulu, Jr., Robert M. Politzer, Jiahong Xu. "America's Health Centers: Reducing racial and Ethnic Disparities in Perinatal care and Birth Outcomes." *Health Services Research*. December 2004. 39:6, Part 1.

distinguish between health center patients and other patients when reporting such data (pre-term births and infant mortality).

The only health centers that were able to report pre-term birth and infant mortality data for 2005 through their own record keeping systems were Eric B. Chandler Health Center (Middlesex county), Newark Community Health Centers, Inc. (Essex County), and Southern Jersey Family Medical Centers, Inc (Atlantic, Salem, and Burlington Counties). In 2005, among Middlesex county births, 1.6% newborns were born in the very pre-term (less than 1500 grams) category; 9.1% were pre-term category (between 1500 and 2500 grams); and 89.3% were born in the full term category (2500 grams or higher). Compared to these numbers, Eric B. Chandler Center which operates in this service area, performs much better in all term/birth categories. For Eric B. Chandler, 0% of newborns were born in the very pre-term category; 1.6% was in the pre-term category, and 98.4% were born in the full-term category.

In the Essex county area, in 2005, 3% births were in the very pre-term category; 10% in the pre-term category; and 87% were born in the full term category. During that same period, Newark Community Health Center, Inc. (NCHC), which provides prenatal care services in the area reported 2.1% very pre-term, 11.7% pre-term, and 86.2% full-term births. While the very pre-term birth numbers are better for the health center, performance in other category of term-births is comparable to other service providers in the area.

The third health center which tracks pre-term births and infant mortality numbers for its prenatal care patients is the Southern Jersey Family Medical Center, Inc. (SJFMC). This health center provides prenatal care services to medically underserved populations

in the Atlantic, Burlington , and Salem counties. In 2005, in these three counties, 1.7% newborns were born in the very pre-term birth category; 8.7% were born in the pre-term birth category; and 89.6% newborns were born in the full-term birth category. For the same period, SJFMC reported less than 1% (.19%) births in the very pre-term birth category; 3.8% births in the pre-term birth category; and 96% births in the full-term birth category. In almost all cases of birth outcomes, overall health center performance is better than or comparable to other prenatal care providers in their service areas.

As indicated earlier, by virtue of providing health care services to the underserved populations in New Jersey, health centers extend care to a large segment of the population that may otherwise lack timely access to health care. While birth outcome data may not be the only criterion for measuring quality of care in prenatal care services, these data clearly indicate that health center patients' birth outcomes are generally better than birth outcomes throughout the state. Due to unavailability of data, this report is limited to comparison between health center birth outcomes and statewide birth outcomes data only. Future analysis focused on various components of the prenatal care programs at the health centers (nutritional guidance, education focused on health risk issues, ease of access to medical providers) can add qualitative value to this primarily quantitative assessment of health center performance in the prenatal care arena.